

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03040

3072 Items 1, 7 Film G226 3-24-58 et

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
<i>Calvert</i> MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. LENGTH OF STAY IN 1b <i>Prince Frederick</i>		d. STREET ADDRESS <i>Mechanicsville 18X-2</i>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert C. Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Johnson</i>		First <i>John</i>	Middle <i>Alvay</i>
4. DATE OF DEATH <i>Dec 12, 1958</i>		Last <i>Alvay</i>	Month <i>3</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <i>Single</i>
8. DATE OF BIRTH <i>Dec 12, 1901</i>		9. AGE (in years from birthday) <i>56</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>John Thomas Alvay</i>		14. MOTHER'S MAIDEN NAME <i>May Bubbee</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>40-10-1000</i>	
17. INFORMANT <i>Leonard Alvay, Mechanicsville MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Cards vascular disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <i>Coronary embolism</i>	
		(c) <i>Had a cerebral hemorrhage 1 yr ago</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> <i>20c. TIME OF INJURY: Month, Day, Year Hour a.m. 4/10/31/58</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Had been up and about heavily all day, fainted</i>	
20c. TIME OF INJURY: Month, Day, Year Hour a.m. 4/10/31/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, office, store, office/bldg., etc.) <i>None</i>		20f. (City or town) <i>Prince Frederick Calvert</i>	
		(County) <i>Morganza</i> (State) <i>Maryland</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and found the death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <i>3/15/58</i>	
ACTUAL SIGNATURE <i>H. W. Alvay</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/17/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Joseph's</i>		22d. LOCATION (City, town, or county) (State) <i>Morganza Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</i>		ADDRESS	
		24a. REC'D BY REGISTRAR <i>11858</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</i>	

RECEIVED
BUREAU OF INVESTIGATION - LOS ANGELES

BUREAU V. S.

MAR 4 9 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3073

CERTIFICATE OF DEATH

03038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 74 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Abraham	Middle	Last Brown	4. DATE OF DEATH March 30 1958	Month Day Year
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/12/84	9. AGE (in years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None-Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph Brown		14. MOTHER'S MAIDEN NAME Sophia Brown		Address Ravica Morell, Owings md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 420.1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { and arteriosclerosis		2 days			
DUE TO {					
DUE TO {					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28, 1958 , to March 30, 1958 , that I last saw the deceased alive on March 30, 1958 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Huntingtown, Maryland DATE SIGNED 3/30/58					
ACTUAL SIGNATURE G. Weems M.D.					
PHYSICIAN'S NAME (Type) Dr. George J. Weems					
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-2-58	22b. DATE THEREOF 4-2-58	22c. NAME OF CEMETERY OR CREMATORIUM mt. Hope		22d. LOCATION (City, town, or county) (State) Sunderland md	
23. FUNERAL DIRECTOR'S SIGNATURE P. J. Sewell, Jr. Fred.		ADDRESS	24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE D. L. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELYÉD 1958. 7. 22.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG227 4-2-58 et

3174

CERTIFICATE OF DEATH

Reg. Dist. No.

03039

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 17 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunderland		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Murray Claggett		First	Middle	Last	4. DATE OF DEATH Mar. 21 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 16-1894	9. AGE (In years lost birthday) 63 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Charles Claggett		14. MOTHER'S MAIDEN NAME Katie Thomas						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Son-James Claggett		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C. R. D disease		DUE TO 442X				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO 						
DUE TO 		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sunderland	(County)	(State)
21. I certify that I attended the deceased from 2-10 , 19 58 , to 3/21 , 19 58 , that I last saw the deceased alive on 3/2 , 19 58 , and that death occurred at 4 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Holiday Inn Sunderland Md		
ACTUAL SIGNATURE Dr. George Weems						DATE SIGNED		
PHYSICIAN'S NAME (Type)								
22a. BURIAL/CREMATION REMOVAL (Specify) 3-23-58		22b. DATE THEREOF 3-23-58		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope		22d. LOCATION (City, town, or county) Sunderland		(State) Md
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Scovell		ADDRESS P. E. Scovell P. Fried. Md		24a. REC'D BY REGISTRAR MAR 26 '58		24b. REGISTRAR'S SIGNATURE W. Weber		

MAR 25 1953

PEGEIY EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1. File No. 3-17-58 et

3075

CERTIFICATE OF DEATH

03041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale Park</i>		b. COUNTY <i>Calvert</i>	
c. LENGTH OF STAY IN lb <i>746 days approx.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holland Point md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>County Hospt. Tah</i>		d. STREET ADDRESS <i>Prince Frederick, Md</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Bertha</i>	Middle <i>Gamble</i>	Last <i>3 - 4 1958</i>
4. DATE OF DEATH	Month <i>3</i>	Day <i>4</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6. 18</i>
9. AGE (In years lost birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>73</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Aha.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James Thomas</i>	14. MOTHER'S MAIDEN NAME <i>Jane Thomas</i>	Address <i>Doris White Pr. Fred, Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) — DUE TO (c) — <i>Hyperthyroid heart disease</i> <i>Hyperthyroidism</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 15, 1958</i> , to <i>March 4, 1958</i> , that I last saw the deceased alive on <i>Mar 4, 1958</i> , and that death occurred at <i>630 M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>F. J. Hennessy</i> PHYSICIAN'S NAME (Type) <i>R. J. Hennessy</i>			
22d. BURIAL/CREMATION, REMOVAL (Specify) <i>3-7-58</i>	22b. DATE THEREOF <i>3-7-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Carrolls</i>	22d. LOCATION (City, town, or county) (State) <i>Barstow, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell, Pr. Fred, Md</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>Mar 12 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Aut. 12 '58</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURED STATE GOVERNMENT OF HAWAII—SALINOMINE 18

CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

DEATH DATE

CAUSE OF DEATH

DEATH PLACE

DEATH TIME

DEATH MONTH

DEATH YEAR

DEATH HOUR

DEATH MINUTE

DEATH SECOND

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DEATH MINUTE

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DEATH DAY

DEATH MONTH

DEATH YEAR

BUREAU Y. S.

MAR 13 1959

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3076

CERTIFICATE OF DEATH

Reg. Dist. No.

03042

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Edith</i>		4. DATE OF DEATH <i>King 3-8 1958</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-12-1898</i>	
9. AGE (In years last birthday) <i>59 yrs.</i>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country)</i> <i>Calvert, Md.</i>	
13. FATHER'S NAME <i>Thomas Gantt</i>		14. MOTHER'S MAIDEN NAME <i>Clara Hyles</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Florence Saunders, R. Fred.</i>	
17. INFORMANT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chremna</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Cerebral hemorrhage</i> <i>Diseases Mellitus</i>	
		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 8, 58</i> , 1958, to <i>March 5, 58</i> , 1958, that I last saw the deceased alive on <i>March 8, 58</i> , 1958, and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. Williams</i>		ADDRESS (Street, city or town, state) <i>57th Street, Baltimore, Md.</i>	
PHYSICIAN'S NAME (Type) <i>R. De Villarreal</i>		DATE SIGNED <i>3/10</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-11-58</i>		22b. DATE THEREOF <i>3-11-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Brook's</i>		22d. LOCATION (City, town, or county) (State) <i>Mutual, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell - Pr. Fred, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 13 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>A. L. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH—SACRAMENTO, 19

CERTIFICATE OF DEATH

DEATH

DEATH

REGAU V. S.

MAR 13 1928

REGAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03043

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach		c. LENGTH OF STAY IN 1b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle J. O. Last Klein		4. DATE OF DEATH Month March Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Mdse.	
10c. BIRTHPLACE (State or foreign country) Philadelphia, Pa		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Phillip Klein		14. MOTHER'S MAIDEN NAME Bertha Lindorfer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-1168 17. INFORMANT Phillip Klein, Chesapeake Beach, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO arteriosclerosis. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 July, 1955, to 5 Mar, 1958, that I last saw the deceased alive on 1 Mar, 1958, and that death occurred at 10 p. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G. J. Weems		ADDRESS (Street, city or town, state) Huntingtown, Md. DATE SIGNED 3/6/58	
PHYSICIAN'S NAME (Type) G. J. Weems		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Mar. 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery	
22d. LOCATION (City, town, or county) Upper Marlboro, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Hutchins		24a. REC'D BY REGISTRAR DATE MAR 10 '58	
ADDRESS Owings, Md.		24b. REGISTRAR'S SIGNATURE A. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF
CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
MAR 10 1953

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03044

3978 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Cabell.

MARYLAND

City (If outside corporate limits, write RURAL
OR and give nearest town)

Town Prince Frederick.

LENGTH OF STAY
(In this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Cabell Nursing Home.

2. USUAL RESIDENCE (HOME) OF DECEASED

State

County Charles.

City (If outside corporate limits, write RURAL and give nearest town)

Or

Town

Street
Address

Walday. 08X-2

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First) Annie

(Middle)

(Last)

Ma Cauley

4. DATE (Month)
OF
DEATH

March. 18

1958 -

IF UNDER 1 YEAR
Months Deys Hours Min.

5. SEX

Female white

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Widowed.10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Chad's Co West Es Sa

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

Samuel Bubis.

14. MOTHER'S MAIDEN NAME

Stella Marks.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

578-44-0789

17. INFORMANT & ADDRESS

Samuel C McCarthy Hospital and

INTERVAL BETWEEN
ONSET AND DEATH

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421.4 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. (C)

U.S. GOVERNMENT PRINTING OFFICE: 1938 10-1400

A CERTIFICATE OF PRIORITY

TO THE UNITED STATES POSTAL SERVICE

RECEIVED

BUREAU Y.

MAR 21 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03045

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby.</i>	c. LENGTH OF STAY IN lb <i>3 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Lusby.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Arthur J. Moran</i>		d. STREET ADDRESS <i>/</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ARTHOR</i>	Middle <i>BERARD</i>	Last <i>Moran</i>
4. DATE OF DEATH	Month <i>May.</i>	Day <i>4,</i>	Year <i>19 58</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/11/1898</i>
9. AGE (In years last birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>9</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Met engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Engineer</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William J. Moran</i>		14. MOTHER'S MAIDEN NAME <i>Agnes F. Cordoni</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>216-10-2380</i>	
17. INFORMANT <i>Margaret Moran wife</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>	
DUE TO <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Office</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>Md</i>	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>G. J. Weems</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>G. J. Weems</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <i></i>		DATE SIGNED <i>3/4/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>3/4/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>New Cathedral Cem</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. O. Harkness & Son - Mutual, Md.</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>MAR 6 58</i>
			24b. REGISTRAR'S SIGNATURE <i>West</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE POLICE DEPARTMENT - MILWAUKEE
POLICE EXAMINER'S CERTIFICATE OF DEATH

BUREAU X-5

AR 6 1969

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3080

CERTIFICATE OF DEATH

Reg. Dist. No.

03046

1. PLACE OF DEATH a. COUNTY <i>Cabret</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Henry</i>	Middle <i>B. Poehler</i>	Last 4. DATE OF DEATH Month <i>Mar. 10</i> Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 6, 1909</i>
9. AGE (In years lost birthday) <i>48 yrs.</i>	10. IF UNDER 1 YEAR <i>5 months</i>	11. IF UNDER 24 HRS. <i>4 days</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Operator</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>Filling Station</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Clarence Poehler</i>		14. MOTHER'S MAIDEN NAME <i>Margaret May</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-10-125</i>	
17. INFORMANT <i>Julia Poehler - Prince Frederick, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>156.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Bairstow - Cabret Co - Md.</i>	
21. I certify that I attended the deceased from <i>Sept</i> , 19 <i>57</i> , to <i>March 10, 1958</i> , that I last saw the deceased alive on <i>Mar 10</i> , 19 <i>58</i> , and that death occurred at <i>Prince Frederick</i> , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Prince Frederick</i>			
ACTUAL SIGNATURE <i>PAGE C JETT MD</i>		DATE SIGNED <i>3/11/58</i>	
PHYSICIAN'S NAME (Type) <i>PAGE C JETT MD</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 14, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Asbury Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Bairstow - Cabret Co - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>O. A. Hackness & Son - Mortuary, Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 17 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3081

CERTIFICATE OF DEATH

Reg. Dist. No. 03047

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick,		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3012 Elizabeth Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Billie	Middle Mae	Last Ridgely	4. DATE OF DEATH	Month March	Day 5	Year 1958	
S. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1952	9. AGE (In years lost birthday) 5 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William J. Ridgely				14. MOTHER'S MAIDEN NAME Eva Mae Gott				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		3012 Elizabeth Ave. Mrs. William Ridgely, Baltimore 30, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inevitable shock DUE TO 510.1 INTERVAL BETWEEN ONSET AND DEATH of m/s Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Loss of blood following removal of kidney & tonsil DUE TO after 12 hrs pt lost some blood which was blamed by shock (c) 20								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3/12 , 19 58 , to 3/15 , 19 58 , that I last saw the deceased alive on 3/15 , 19 58 , and that death occurred at Owings , from the causes and on the date stated above. ACTUAL SIGNATURE H. W. Ward M.D. ADDRESS (Street, city or town, state) Owings DATE SIGNED 3/15/58								
PHYSICIAN'S NAME (Type) H. W. Ward, Owings, Maryland								
220. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Near Owings, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Ward		ADDRESS Owings, Maryland		24a. REC'D BY REGISTRAR MAR 7 '58	24b. REGISTRAR'S SIGNATURE W. L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - SANITATION
CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1959

REGISTRY FILE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03048

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean Beach</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret Louise Stevens</i>		First <i>Louise</i>	Middle <i>Louise</i>
4. DATE OF DEATH <i>Jan 9/58</i>		Month <i>3</i>	Day <i>9</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan 9/58</i>		9. AGE (in years last birthday) yrs. <i>80</i>	10. IF UNDER 1 YEAR Months <i>0</i>
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. IF UNDER 24 HRS. Hours <i>80</i>	13. IF OVER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Donald G. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Martha Louise Stevens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mother</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory infection</i> DUE TO <i>527.2</i> Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Found dead in bed</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month Day Year <i>Jan 9/58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Sunderland</i> (County) <i>MD</i> (State) <i>MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>K. Hassell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL / CREMATION, REMOVAL (Specify) <i>3-22-58</i>		22b. DATE THEREOF <i>3-22-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Edmonds</i>		22d. LOCATION (City, town, or county) <i>Sunderland</i> (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell, Jr. Fred MD</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE <i>MAR 26 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Aut. death</i>	

RECEIVED
BUREAU X, S

MAR 26 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG226 3-20-58 et

3083

CERTIFICATE OF DEATH

Reg. Dist. No.

03049

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	c. LENGTH OF STAY IN lb 64 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First William	Middle L	Last Thomas
4. DATE OF DEATH Month March	Day 5	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27 1872
9. AGE (In years last birthday) 85 8/9 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Thomas	14. MOTHER'S MAIDEN NAME Mary Thomas	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT Son--Edward Thomas Owings	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Jangence of feet + Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 months	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension C.V.R disease		DUE TO Indifferent	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walked in snow barefoot.		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Burke Frederick DATE SIGNED 3/6/58			
ACTUAL SIGNATURE Page Jett	M.D.		
PHYSICIAN'S NAME (Type) Dr. Page Jett			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-4, 58	22b. DATE THEREOF 3-4, 58	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope	22d. LOCATION (City, town, or county) Sunderland (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell Prince Frederick	ADDRESS 111 E. Main St. Prince Frederick	24a. REC'D BY REGISTRAR DATE MAR 13 '58	24b. REGISTRAR'S SIGNATURE A. L. Smith

MAR 13 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3084

CERTIFICATE OF DEATH

Reg. Dist. No.

03050

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE					
<i>Oakwood</i> MARYLAND		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN Tb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>Owings</i>	X <i>Owings</i>	d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>E</i>	Last <i>Wood</i>				
4. DATE OF DEATH	Month 3	Day 4	Year 1958				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 23, 1883</i>	9. AGE (In years less birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Wife</i>	<i>Domestic</i>	<i>MD</i>	<i>U.S.A.</i>				
13. FATHER'S NAME <i>Wm Haudeby</i>	14. MOTHER'S MAIDEN NAME <i>Ella Johnson</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Joseph Johnson</i>	Address <i>Oney Rd</i>
Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)			Carcinoma of Colon			INTERVAL BETWEEN ONSET AND DEATH <i>153.8</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b)			Cardio vascular renal disease			?	
DUE TO (c)			Coronary embolism			1 hr	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <i>Jan 1, 1958</i> , to <i>Mar 4, 1958</i> , that I last saw the deceased alive on <i>Mar 4, 1958</i> , and that death occurred at <i>3304 W. Owings Rd.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. W. Ward</i>	ADDRESS (Street, city or town, State) <i>Owings Md</i>						
PHYSICIAN'S NAME (Type) <i>H. W. Ward</i>	DATE SIGNED <i>3/4/58</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-6-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Friendship</i>	22d. LOCATION (City, town, or county) <i>Friendship Md</i>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Hutchins</i>	ADDRESS <i>Owings Md</i>	24a. REC'D BY REGISTRAR DATE MAR 7 '58	24b. REGISTRAR'S SIGNATURE <i>Asst. Secy</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

MAR 7 1959